For your information and comments.

DEPARTMENT OF HEALTH & HUMAN SERVICES

National Institutes of Health
National Cancer Institute

Memorandum

Date August 4, 1994

From Chief, LMI, BRMP, DCT, NCI

Subject Summary of NCI/DCT Lab and Branch Chief's Meeting of August 2, 1994

To BRMP Lab/Branch Chiefs and Associate Director, BRMP

The forty or so DCT program leaders held their quarterly mandatory meeting with Dr. Bruce Chabner on August 2, 1994. The agenda of the meeting proposed to cover the usual topics such as the status of women, changes in tenure track policies, the impact of the report of the external advisors, training in ethics, property inventory and last but not least an update on the NCI, DCT budget and FTE situation. I will attempt to convey in brief the rather surprising and unsettling discussion that ensued.

The meeting was enlivened by the presence of Dr. Samuel Broder, Director, NCI who offered to answer any and all questions concerning the NCI. The first topic concerned the changes in tenure track which we were told will prolong the training period of NIH scientists and is designed to provide greater independence for young NCI scientists. The actual consequences of the proposed changes were questioned by a number of lab chiefs who felt that this would actually result in diminished team effort and collaborative studies between NIH scientists. Drs. Chabner and Broder strongly disagreed, and felt that a major impact of these changes would be to reduce the aggrandizing behavior of lab chiefs who automatically assume senior authorship on all papers originating from their laboratories. There was also a brief discussion of the probable need to reduce the DCT FTE roster by an additional 28 during the next fiscal year.

Dr. Chabner pointed out that non-FTE training positions ("general fellowships") which pay only $16-20,000/year should not be abused in a misguided effort to compensate for the lack of technical help that has resulted from the recent Draconian cuts in FTE's. Several lab chief's indicated they were just using one of the few remaining options to staff their laboratories.

In response to questions by a frustrated senior scientist (e.g. yours truly), Dr. Broder stated that he was against fusing the three NCI divisions into one because they serve very different functions and this would not result in significant savings. He felt that the unique role of the Division of Cancer Treatment (DCT), in particular, is to develop drugs and natural products to be tested clinically on cancer patients. He indicated that the intramural program of the NCI uses 18% of the NCI budget (e.g. $360,000,000/yr), exclusive of contracts that support the intramural program such as the ones at Frederick. He considers developmental research the only justification for spending so much of the NCI budget over the 11.3% recommended for intramural activities. It should be noted that despite this the overall NIH intramural spending

level is at 11%. These developmental activities cannot be pursued by academia and are not considered cost effective by industry. Therefore, the intramural program of the NCI is unique in fostering the development of drugs, agents and natural products from the laboratory to the bedside treatment of cancer patients. This justifies an expenditure of 25% of the intramural budget of $90,000,000 for clinical research and additional large outlays for screening drugs for anticancer activity.

Another question by the frustrated scientist to wit, whether the clinical branches of the NCI would be reduced as the clinical center will be down-sized to 250 beds to save money and preserve basic research laboratories was not answered. However, it was pointed out that support for both the clinical branches as well as the basic laboratories of the DCT/NCI was being painfully reduced. Furthermore, it was emphasized that if one was interested merely in pursuing fundamental research, this could be done extramurally with grant support, and that merely pursuing basic research could not justify the large intramural NCI budget. The scientists contention that the intramural program offers scientists the opportunity to pursue long term higher risk basic research projects, was countered by Dr. Chabner's comment that this could best be achieved by Hughes support outside the NCI. Dr. Broder stressed, in no uncertain terms, that it was particularly important for the BRMP of the DCT to pursue more developmental studies in the laboratory and clinic. He did comment that the identification of cytokines with antitumor activities provides a good example of developmental research. When told that we more often succeed in identifying cytokines that promote tumor growth, we were told that this provides a terrific opportunity to identify antagonists.

The session provided a rare opportunity to learn how the NCI leadership views our mission. It is perplexing how, in the face of shrinking personnel and budgetary resources, we are to cope on the one hand with the requirement to develop more independent young scientists that can achieve tenure, and on the other hand to pursue applied research aimed at developing drugs, agents, natural products and antagonists all of which requires a major collaborative team effort. Dr. Howard Young of the BRMP pointed out that although the BRMP is supposed to develop more Biological Response Modifiers, the enormous DCT drug screening effort only detects agents that directly impair tumor cell growth in vitro, but does not identify agents that modify host response for the BRMP to develop. Consequently, we have to have our own discovery programs to identify agents that modify host defense against tumors as well as to develop them preclinically and clinically. It was therefore disappointing to learn that basic discovery research was considered of limited value.

As scientists we also consider elucidation of basic mechanisms and identification of participating molecules as key to gaining a greater understanding of the process of malignancy. Such basic research studies may eventually reveal ways of effectively dealing with malignant disease development and progression. We agree with the need for developing and testing new agents and that discoveries can be made through the impetus of clinical research. However, we hope the NCI leadership develops greater

appreciation for basic research in the DCT intramural program. We believe that a strong commitment to all three areas (basic research, developmental research and investigative clinical research) and an organizational structure designed to facilitate active and continuous interaction between these areas, will enable the NCI intramural program to be successful. Support for only two of the three areas will inevitably result in a large expenditure of funds for drug screening and clinical trials which will far outweigh the benefits obtained.

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